		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020131

Facility Name: JACKSONVILLE CONVALESCENT CENTER

Address: 1517 WEST WALNUT (Number) JACKSONVILLE (City) 62650 (Zip Code)

County: MORGAN

Telephone Number: (217) 243-6451 **Fax #** (217) 243-8295

IDPA ID Number: 370983545001

Date of Initial License for Current Owners: 8/74

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** (217) 787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	61	Skilled (SNF)	61	22,265	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,855	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,120	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	203	30	3,615	3,848	8
9	SNF/PED					9
10	ICF	15,131	8,246		23,377	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,334	8,276	3,615	27,225	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.76%

D. How many bed-hold days during this year were paid by Public Aid?
20 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/74

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 3,615

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/01 Fiscal Year: 06/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENT # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	88,936	10,344	4,787	104,067		104,067		104,067			1
2	Food Purchase		92,622		92,622		92,622	(939)	91,683			2
3	Housekeeping	33,747	9,338		43,085		43,085		43,085			3
4	Laundry	20,697	5,628		26,325		26,325		26,325			4
5	Heat and Other Utilities			62,909	62,909		62,909		62,909			5
6	Maintenance	35,958	24,774	28,167	88,899		88,899	701	89,600			6
7	Other (specify):* Utility Workers	30,110			30,110		30,110		30,110			7
8	**TOTAL General Services**	209,448	142,706	95,863	448,017		448,017	(238)	447,779			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	657,310	96,798	124,567	878,675	(57,800)	820,875	1,277	822,152			10
10a	Therapy	17,685	184	125,381	143,250	(125,381)	17,869		17,869			10a
11	Activities	24,471	534		25,005		25,005		25,005			11
12	Social Services	9,023		2,058	11,081		11,081		11,081			12
13	Nurse Aide Training	1,905	36	1,607	3,548		3,548		3,548			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	710,394	97,552	265,613	1,073,559	(183,181)	890,378	1,277	891,655			16
	C. General Administration											
17	Administrative	51,897		13,247	65,144	2,012	67,156	32,754	99,910			17
18	Directors Fees											18
19	Professional Services			232,781	232,781		232,781	(224,922)	7,859			19
20	Dues, Fees, Subscriptions & Promotions			18,269	18,269		18,269	(5,520)	12,749			20
21	Clerical & General Office Expenses	15,725	8,702	4,794	29,221		29,221	15,545	44,766			21
22	Employee Benefits & Payroll Taxes			158,192	158,192		158,192	10,223	168,415			22
23	Inservice Training & Education			604	604		604	57	661			23
24	Travel and Seminar			4,062	4,062	(3,832)	230	1,225	1,455			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			76,069	76,069		76,069	364	76,433			26
27	Other (specify):*			16,793	16,793		16,793	(16,793)				27
28	**TOTAL General Administration**	67,622	8,702	524,811	601,135	(1,820)	599,315	(187,067)	412,248			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	987,464	248,960	886,287	2,122,711	(185,001)	1,937,710	(186,028)	1,751,682			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER #0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			11,406	11,406		11,406	8,112	19,518			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			25,420	25,420		25,420		25,420			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(128,159)	3,841			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			168,826	168,826		168,826	(120,047)	48,779			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					185,001	185,001		185,001			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			48,180	48,180	185,001	233,181		233,181			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	987,464	248,960	1,103,293	2,339,717		2,339,717	(306,075)	2,033,642			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,379)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(1,315)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,087)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(330)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,238)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,781)	27		24
25	Fund Raising, Advertising and Promotional	(4,920)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,925)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(479)	20		28
29	Other-Attach Schedule VENDING	(939)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,393)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(277,682)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (277,682)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (306,075)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39	Therapy	X		125,381	10a	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	X		484	10	42
43	Prescription Drugs	X		48,738	10	43
44	Exceptional Care Program					44
45	Other-Attach Schedule I.V. Therapy	X		6,076	10	45
46	Other-Attach Schedule Oxygen	X		4,322	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 185,001		47

STATE OF ILLINOIS

JACKSONVILLE CONVALESCENT CENTER

ID# 0020131

Report Period Beginning: 07/01/00

Ending: 06/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	551	0	0	0	0	0	0	0	0	0	551	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,238)	(223,790)	0	0	0	0	0	0	0	0	0	(225,028)	19
20	Fees, Subscriptions & Promotions	(5,729)	150	0	0	0	0	0	0	0	0	0	(5,579)	20
21	Clerical & General Office Expenses	(1,315)	0	0	0	0	0	0	0	0	0	0	(1,315)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(551)	0	0	0	0	0	0	0	0	0	(551)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(16,793)	0	0	0	0	0	0	0	0	0	0	(16,793)	27
28	**TOTAL General Administration**	(25,075)	(223,640)	0	0	0	0	0	0	0	0	0	(248,715)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,075)	(223,640)	0	0	0	0	0	0	0	0	0	(248,715)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER **#** 0020131 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,379)	8,782	0	0	0	0	0	0	0	0	0	6,403	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(132,000)	0	0	0	0	0	0	0	0	0	(132,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,379)	(123,218)	0	0	0	0	0	0	0	0	0	(125,597)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(27,454)	(346,858)	0	0	0	0	0	0	0	0	0	(374,312)	45

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN	25%	D'ADRIAN CONVALESCENT CENTER	GODFREY	NursingHomeMngrs	SPRINGFIELD	MANGEMENT
SAM KLEIN	25%	HILLTOP NURSING HOME	CHARLESTON	J'ville Land Trust	SPRINGFIELD	LAND TRUST
DORYS BERG, TRUSTEE	50%	MEADOW MANOR	TAYLORVILLE			
		MENARD CONVALESCENT CENTER	PETERSBURG			
		SUNRISE MANOR OF VIRDEN	VIRDEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 132,000	JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	$	$ (132,000)	1
2	V	30	DEPRECIATION		JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	8,782	8,782	2
3	V	20	TRUST FEES		JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	150	150	3
4	V								4
5	V								5
6	V	19	MANGEMENT FEES	231,278	NURSING HOME MANAGERS, INC.	50.00%		(231,278)	6
7	V	VAR	SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC.	50.00%	69,176	69,176	7
8	V	19	ACCOUNTING		NURSING HOME MANAGERS, INC. - DIRECT ALLOCATIO	50.00%	7,488	7,488	8
9	V	24	TRAVEL	551	TO TRANSFER 31% OF HOME OFFICE TRAVEL	50.00%		(551)	9
10	V	17	ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE PER DESK REVIEW	50.00%	551	551	10
11	V								11
12	V								12
13	V								13
14	Total			$ 363,829			$ 86,147	$ * (277,682)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CEN # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	SAM KLEIN	PRESIDENT	MANAGEMENT	25%					$ 1,865	17 - 7	1
2	H. RAYMOND KLEIN	OWNER		25%					1,865	17 - 7	2
3											3
4											4
5											5
6		SAM KLEIN AND H. RAYMOND KLEIN WERE PAID BY NURSING HOME MANAGERS, INC.,									6
7		A RELATED ORGANIZATION. TOTAL COMPENSATION OF $10,010 FOR EACH WAS									7
8		ALLOCATED AMONG THE SIX RELATED NURSING HOMES, BASED UPON 10 HOURS PER									8
9		WEEK FOR SAM KLEIN AND 10 HOURS PER WEEK FOR H. RAYMOND KLEIN.									9
10											10
11											11
12											12
13								TOTAL	$ 3,730		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC.
Street Address: 2653 WEST LAWRENCE - SUITE B
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE ATTACHED SCHEDULES				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENT # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$ 37,672	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 25,114	2
3. Under or (over) accrual (line 2 minus line 1).	$ (12,558)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 37,978	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 25,420	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1996	30,537	8
1997	31,641	9
1998	31,046	10
1999	25,115	11
2000	25,319	12

LINE 4: 2000 TAX BILL $25,319
6/12 OF $25,319 + $12,659
= $37,978

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME JACKSONVILLE CONVALESCENT CENTER COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0020131

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE (217) 787-8530 FAX #: (217) 787-9840

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-18-301-002	JACKSONVILLE CONV. CENTER	$ 25,318.58	$ 25,318.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 25,318.58	$ 25,318.58

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,061 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1974	$ 35,003	1
2	TITLE WORK		1989	426	2
3	TOTALS			$ 35,429	3

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1974	1974	$ 541,766	$ 6,712	30	$	$ (6,712)	$ 541,766	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1975	3,850		5			3,850	9
10	AIR CONDITIONING/HEATING			1974	14,470		8			14,470	10
11	MOTORS			1980	533		5			533	11
12	BIDS			1981	739	22	30	25	3	508	12
13	FURNACE			1981	678		8			678	13
14	FAN			1981	972		15			972	14
15	USED AIR CONDITIONER			1982	2,000		8			2,000	15
16	VACUUM REPAIR (PER 1982 AUDIT)			1982	1,031		10			1,031	16
17	FLOORING			1983	1,229		10			1,229	17
18	WATER HEATER			1983	1,498		8			1,498	18
19	WATER HEATER			1983	1,575		8			1,575	19
20	CEILING AND DOORS			1984	2,041		15			2,041	20
21	ASPHALT			1984	13,350		15			13,350	21
22	AIR CONDITIONER			1987	1,155		8			1,155	22
23	SIDEWALKS			1987	6,700	213	20	335	122	4,523	23
24	ROOF			1988	21,783	692	20	1,089	397	13,612	24
25	LIGHT DIFFUSER			1990	1,054	33	10		(33)	1,054	25
26	FLOORING			1990	1,030	33	15	69	36	723	26
27	WATER HEATER			1992	1,450	46	15	97	51	920	27
28	AIR CONDITIONER			1992	1,025		10	103	103	873	28
29	REWIRE FIXTURES			1992	1,110	35	10	111	76	944	29
30	COMPRESSOR			1993	1,479	38	10	148	110	1,109	30
31	DOOR STOPS			1993	2,168	56	15	144	88	1,081	31
32	ROOF			1993	34,178	876	20	1,709	833	12,816	32
33	FIRE DOORS			1996	1,011	26	15	67	41	369	33
34	WATER HEATER			1997	3,915	100	15	261	161	1,099	34
35	AIR CONDITIONER			1997	5,982	153	10	598	445	2,392	35
36	SWAMP COOLER			1998	1,125	29	8	141	112	446	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	1998	$ 1,950	$ 50	15	$ 130	$ 80	$ 357	37
38	DOOR ENTRANCE	1999	2,672	69	15	178	109	312	38
39	SHUTTERS	1999	912	23	15	61	38	101	39
40	DOOR ENTRANCE	2000	4,507	116	15	300	184	350	40
41	DUCT SMOKE DETECTORS	2000	2,295	52	20	105	53	105	41
42	DOOR	2000	2,280	41	15	114	73	114	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 685,513	$ 9,415		$ 5,785	$ (3,630)	$ 629,956	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 114,936	$ 8,686	$ 10,751	$ 2,065	Various	$ 60,302	71
72	Current Year Purchases	14,189	2,087	1,273	(814)	Various	1,273	72
73	Fully Depreciated Assets	122,791					122,791	73
74	Assets no longer in service	(77,603)					(77,603)	74
75	TOTALS	$ 174,313	$ 10,773	$ 12,024	$ 1,251		$ 106,763	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 895,255	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 20,188	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 17,809	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,379)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 736,719	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: JACKSONVILLE CONVALESCENT CENTER LAND TRUST

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	88	08/01/74	$ 132,000			3
4	Additions							4
5								5
6								6
7	TOTAL		88		$ 132,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 07/01/00
Ending 06/30/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	06/30/02	$ 132,000
13.	06/30/03	$ 132,000
14.	06/30/04	$ 132,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ Description: INCLUDED IN THE ABOVE AMOUNT
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 84

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			36		36
3	Classroom Wages	(a)	669	824		1,493
4	Clinical Wages	(b)		412		412
5	In-House Trainer Wages	(c)				
6	Transportation		48	216		264
7	Contractual Payments		797	546		1,343
8	Nurse Aide Competency Tests					
9	TOTALS		$ 1,514	$ 2,034	$	$ 3,548
10	SUM OF line 9, col. 1 and 2	(e)	$ 3,548			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	5
2. From other facilities (f)	
TOTAL TRAINED	7

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 8	hrs	$	912	$	44,229	$	912	$ 44,229	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		372		18,586		372	18,586	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 8	hrs		1,517		62,566		1,517	62,566	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 8	# of prescrpts					48,738		48,738	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Oxygen,Lab, & IV's	39 - 8						10,882		10,882	13
14	TOTAL			$	2,801	$	125,381	$ 59,620	2,801	$ 185,001	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 170,956	$ 174,480	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	376,634	376,634	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,878	16,878	6
7	Other Prepaid Expenses	78,168	78,168	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 642,636	$ 646,160	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		35,429	13
14	Buildings, at Historical Cost		658,844	14
15	Leasehold Improvements, at Historical Cost	25,638	25,638	15
16	Equipment, at Historical Cost	157,811	249,975	16
17	Accumulated Depreciation (book methods)	(131,395)	(811,257)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 52,054	$ 158,629	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 694,690	$ 804,789	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 118,252	$ 118,252	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,419	45,419	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,171	8,171	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,978	37,978	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,925	8,925	35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 218,745	$ 218,745	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 218,745	$ 218,745	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 475,945	$ 586,044	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 694,690	$ 804,789	48

***(See instructions.)**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 502,167	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 502,167	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	580,632	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(486,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Land Trust Income**	123,245	15
16	Other (describe) **Land Trust Distribution to Owners**	(134,000)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 83,877	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 586,044	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,890,978	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,890,978	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	17,188	6
7	Oxygen	933	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 18,121	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,791	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,791	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,195	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,195	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending $939 - Admit Fee $750 - W/A $40	1,729	28
28a	Bad Debt Recovery $10 - Old Checks $525	535	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,264	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,920,349	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	448,017	31
32	Health Care	1,073,559	32
33	General Administration	601,135	33
	B. Capital Expense		
34	Ownership	168,826	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	48,180	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,339,717	40
41	**Income before Income Taxes (line 30 minus line 40)****	580,632	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 580,632	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 40,305	$ 19.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,263	4,407	70,589	16.02	3
4	Licensed Practical Nurses	15,666	16,300	188,508	11.56	4
5	Nurse Aides & Orderlies	40,657	41,646	357,908	8.59	5
6	Nurse Aide Trainees	370	370	1,905	5.15	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,023	2,036	17,685	8.69	8
9	Activity Director	1,643	1,711	13,187	7.71	9
10	Activity Assistants	1,893	1,926	11,284	5.86	10
11	Social Service Workers	1,190	1,218	9,023	7.41	11
12	Dietician					12
13	Food Service Supervisor	2,335	2,391	25,958	10.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,476	9,738	62,978	6.47	15
16	Dishwashers					16
17	Maintenance Workers	3,409	3,649	35,958	9.85	17
18	Housekeepers	5,464	5,634	33,747	5.99	18
19	Laundry	2,749	2,916	20,697	7.10	19
20	Administrator	2,000	2,080	51,897	24.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,120	2,202	15,725	7.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	5,630	5,703	30,110	5.28	33
34	TOTAL (lines 1 - 33)	102,888	106,007	$ 987,464 *	$ 9.32	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 4,787	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant	16	502	10 - 3	37
38	Nurse Consultant	136	4,261	10 - 3	38
39	Pharmacist Consultant	48	900	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	36	2,058	12 - 3	45
46	Other(specify)				46
47	Administrative Consultant	556	13,247	17 - 3	47
48					48
49	TOTAL (lines 35 - 48)	1,104	$ 37,755		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	63	$ 2,255	10 - 3	50
51	Licensed Practical Nurses	1,617	53,192	10 - 3	51
52	Nurse Aides	3,370	63,457	10 - 3	52
53	TOTAL (lines 50 - 52)	5,050	$ 118,904		53

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANNA NEWINGHAM	ADMINISTRATOR	0%	$ 51,897
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 51,897

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 13,247
TOTAL (agree to Schedule V, line 17, col. 3)	$ 13,247
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT	$ 231,278
DUDLEY & SMITH	LEGAL	842
Feldman,Wasser,Draper&Benson	LEGAL	396
C S C	CORP REPRESENTATION	265
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 232,781

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,251
Unemployment Compensation Insurance	14,644
FICA Taxes	72,524
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
SECTION 125 PLAN	14,986
EMPLOYEE LIFE INSURANCE	1,395
HBV VACCINE	932
CHRISTMAS PARTY	500
GIFT CERTIFICATES	960
NURSING HOME MANAGERS ALLOCATION	10,223
TOTAL (agree to Schedule V, line 22, col.8)	$ 168,415

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
HBV VACCINE	22	$ 932
CHRISTMAS PARTY	22	500
GIFT CERTIFICATES	22	960
TOTAL		$ 2,392

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	11,274
Health Care Worker Background Check	1,116
(Indicate # of checks performed 93)	
SEE ATTACHED SCHEDULE	5,679
J'VILLE LAND TRUST - TRUST FEES	150
NURSING HOME MANAGERS ALLOC.	59
Less: Non-allowable Dues & Fees	(330)
Less: Public Relations Expense	(4,920)
Non-allowable advertising	( )
Yellow page advertising	(479)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,749

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Miscellaneous Mileage Reimbursement	230
Nursing Home Managers Allocation	1,225
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,455

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Paint	7/90 - 6/91	$ 1,384	3 YRS	$	$	$	$	$	$	$	$	$
2	Interior Paint	7/92 - 6/93	1,970	3 YRS									
3	Wallpaper & Paint	7/93 - 6/94	6,214	3 YRS									
4	Wallpaper & Paint	7/94 - 6/95	3,051	3 YRS	508								
5	Wallpaper & Paint	7/96 - 6/97	4,944	3 YRS	1,648	1,648	824						
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 17,563		$ 2,156	$ 1,648	$ 824	$	$	$	$	$	$

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER **#** 0020131 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,031** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **48,180**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V - PAGE 3 & 4

LINE 27 - GENERAL ADMINISTRATION - OTHER

SALES TAX	$	3,087
BAD DEBTS		4,781
ILLINOIS RT TAX		8,925
TOTAL LINE 27 - COLUMN 3	$	16,793

DETAIL COLUMN 5 - RECLASSIFICATIONS

RECLASS TO:			LINE
NURSES CONSULTANT TRAVEL	$	1,820	10
ADMINISTRATIVE CONSULTANT TRAVEL		2,012	17
RECLASS FROM: TRAVEL	$	(3,832)	24

RECLASS FROM:			
MEDICARE DRUGS	$	(48,738)	10
MEDICARE LABORATORY FEES		(484)	10
MEDICARE I.V. THERAPY		(6,076)	10
OXYGEN		(4,322)	10
PHYSICAL THERAPY		(62,566)	10a
SPEECH THERAPY		(18,586)	10a
OCCUPATIONAL THERAPY		(44,229)	10a
RECLASS TO:			
ANCILLARY SERVICES	$	185,001	39

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a
a
a

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION

LINE 83 - STRAIGHT LINE DEPRECIATION	$	17,809
NURSING HOME MANAGERS ALLOCATION		1,709
SCHEDULE V - LINE 30 - COLUMN 8	$	19,518

PAGE 15 - SCHEDULE XII

AIDES TRAINED SUNRISE MANOR OF VIRDEN, INC.
333 SOUTH WRIGHTSMAN
VIRDEN, IL 62690

COST PER AIDE TRAINED: 2 @ $273.00

PAGE 23 - SCHEDULE XX

QUESTION #12

SALARY COSTS ARE ALLOCATED TO DEPARTMENT
WORKED BASED UPON TIME CARD.

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME

NET INCOME - LINE 43	$	580,632
* MANAGEMENT FEE 6/30/00		(16,718)
* MANAGEMENT FEE 6/30/01		22,916
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS		(7,195)
TAXABLE INCOME	$	579,635

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED
PURPOSES INCLUDED HERE FOR CONSISTANCY WITH I
COST REPORTS AND TO CONFORM WITH ACCRUAL AC(
METHOD

PAGE 21 - SCHEDULE XIX - SECTION F

DUES, FEES, SUBSCRIPTIONS, AND PROMOTIONS

YELLOW PAGES	$	479
PUBLIC RELATIONS		4,920
CHAMBER OF COMMERCE DUES		180
FRANCHISE FEES		100
	$	5,679

FOR TAX
PRIOR YEAR
COUNTING

CENTRAL OFFICE COST ALLOCATION
JACKSONVILLE
2000

	JULY 00	AUG	SEPT	OCT	NOV	DEC	JAN 01	FEB	MARCH	APRIL	MAY	JUNE	2000 TOTAL	Line #
SALARIES-ADMIN	$2,722	$1,994	$1,915	$1,916	$1,925	$1,916	$2,512	$2,658	$2,683	$2,723	$2,745	$2,763	$28,473	17
SALARIES-CLERIC	1,396	1,052	1,011	1,011	1,016	1,011	1,325	1,402	1,416	1,436	1,448	1,458	14,981	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	0	0	0	0	0	0	199	211	213	216	218	219	1,277	10
ACCOUNTING	9	9	9	9	9	9	8	8	9	9	9	9	106	19
WORK COMP INS	15	25	24	24	24	24	26	27	27	28	28	28	299	22
SUPPLIES	133	38	37	37	37	37	99	105	106	108	109	109	956	21
TELEPHONE	63	98	94	94	94	94	60	64	65	66	66	66	923	21
EMPL BENEFITS	450	526	505	506	508	505	486	514	519	527	531	534	6,112	22
PAYROLL TAXES	335	284	273	273	274	273	328	347	351	356	359	361	3,812	22
TRAVEL	192	223	214	214	215	214	79	83	84	85	86	86	1,776	24
IN SERVICE	13	4	4	4	4	4	4	4	4	4	4	4	57	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	21	0	0	0	0	0	16	17	17	17	18	18	124	6
OWNERS COMP	319	319	307	307	308	307	291	308	311	315	318	320	3,730	17
INS-PROP,LIAB,WC	23	30	29	29	29	29	31	32	33	33	34	34	364	26
DEPRECIATION	148	144	139	139	139	139	135	142	144	146	147	148	1,709	30
RENT	328	320	307	307	309	307	307	325	328	332	335	337	3,841	34
MAINTENANCE	27	48	46	46	47	46	49	52	53	53	54	54	577	6
FEES & PUBLICAT	5	5	5	5	5	5	4	5	5	5	5	5	56	20
ADVERTISING	3	0	0	0	0	0	0	0	0	0	0	0	3	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$6,201	$5,120	$4,918	$4,920	$4,943	$4,918	$5,960	$6,307	$6,365	$6,460	$6,511	$6,554	$69,176	
FIXED ASSETS													69,176	
EQUIP - PRIOR	8,884	8,655	8,314	8,317	8,356	8,314	11,208	11,860	11,971	12,148	12,244	12,326	10,216	
EQUIP - CURR	4,090	3,985	3,828	3,829	3,847	3,828	0	0	0	301	303	305	2,026	
EQUIP - FULLY DEP	1,086	1,058	1,017	1,017	1,022	1,017	1,607	1,700	1,716	1,742	1,755	1,767	1,375	
BLDG - PRIOR	1,301	1,268	1,218	1,218	1,224	1,218	1,186	1,255	1,267	1,285	1,296	1,304	1,253	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

MONTHLY CENTRAL OFFICE
COST ALLOCATIONS

COST ALLOCATION
JULY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.71%	14.72%	19.35%	20.17%	11.78%	15.26%	100.00%
SALARIES-ADMIN	$2,632	$2,071	$2,722	$2,838	$1,657	$2,146	$14,066
SALARIES-CLERIC	1,350	1,062	1,396	1,456	850	1,101	7,216
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	9	5	7	46
WORK COMP INS	14	11	15	15	9	11	75
SUPPLIES	128	101	133	138	81	104	685
TELEPHONE	61	48	63	66	38	50	326
EMPL BENEFITS	435	342	450	469	274	355	2,324
PAYROLL TAXES	324	255	335	349	204	264	1,730
TRAVEL	186	146	192	200	117	151	993
IN SERVICE	13	10	13	14	8	10	68
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	20	16	21	22	13	16	108
OWNERS COMP	309	243	319	333	194	252	1,650
INS-PROP,LIAB,WC	22	18	23	24	14	18	120
DEPRECIATION	143	113	148	155	90	117	766
RENT	317	250	328	342	200	259	1,696
MAINTENANCE	26	20	27	28	16	21	137
FEES & PUBLIC	5	4	5	5	3	4	25
ADVERTISING	3	2	3	3	2	2	13
	0	0	0	0	0	0	0
TOTAL	$5,996	$4,718	$6,201	$6,465	$3,776	$4,889	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,591	6,760	8,884	9,262	5,410	7,004	45,912
EQUIP - CURR	3,955	3,112	4,090	4,264	2,491	3,225	21,138
EQUIP - FULLY DEP	1,051	827	1,086	1,133	662	856	5,614
BLDG - PRIOR	1,258	990	1,301	1,357	792	1,026	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.10%	14.62%	18.85%	20.40%	12.20%	15.82%	100.00%
SALARIES-ADMIN	$1,915	$1,547	$1,994	$2,158	$1,291	$1,674	$10,578
SALARIES-CLERIC	1,010	816	1,052	1,138	681	883	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	10	6	8	50
WORK COMP INS	24	19	25	27	16	21	132
SUPPLIES	37	30	38	42	25	32	204
TELEPHONE	94	76	98	106	63	82	518
EMPL BENEFITS	505	408	526	569	341	442	2,791
PAYROLL TAXES	272	220	284	307	184	238	1,505
TRAVEL	214	173	223	241	144	187	1,183
IN SERVICE	4	3	4	5	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	307	248	319	346	207	268	1,694
INS-PROP,LIAB,WC	29	23	30	32	19	25	158
DEPRECIATION	139	112	144	156	93	121	765
RENT	307	248	320	346	207	268	1,696
MAINTENANCE	46	38	48	52	31	41	257
FEES & PUBLIC	5	4	5	5	3	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$4,917	$3,972	$5,120	$5,540	$3,314	$4,298	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,311	6,715	8,655	9,364	5,602	7,265	45,912
EQUIP - CURR	3,826	3,091	3,985	4,311	2,579	3,345	21,138
EQUIP - FULLY DEP	1,016	821	1,058	1,145	685	888	5,614
BLDG - PRIOR	1,217	984	1,268	1,372	821	1,064	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.02%	14.91%	18.11%	19.77%	13.38%	15.82%	100.00%
SALARIES-ADMIN	$1,906	$1,577	$1,915	$2,092	$1,415	$1,673	$10,578
SALARIES-CLERIC	1,005	832	1,011	1,104	747	883	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	10	7	8	50
WORK COMP INS	24	20	24	26	18	21	132
SUPPLIES	37	30	37	40	27	32	204
TELEPHONE	93	77	94	102	69	82	518
EMPL BENEFITS	503	416	505	552	373	441	2,791
PAYROLL TAXES	271	224	273	298	201	238	1,505
TRAVEL	213	176	214	234	158	187	1,183
IN SERVICE	4	3	4	4	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	305	253	307	335	227	268	1,694
INS-PROP,LIAB,WC	28	24	29	31	21	25	158
DEPRECIATION	138	114	139	151	102	121	765
RENT	306	253	307	335	227	268	1,696
MAINTENANCE	46	38	46	51	34	41	257
FEES & PUBLIC	5	4	5	5	3	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$4,893	$4,049	$4,918	$5,371	$3,633	$4,296	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,272	6,845	8,314	9,078	6,141	7,262	45,912
EQUIP - CURR	3,808	3,152	3,828	4,180	2,828	3,343	21,138
EQUIP - FULLY DEP	1,011	837	1,017	1,110	751	888	5,614
BLDG - PRIOR	1,212	1,003	1,218	1,330	900	1,064	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.14%	14.64%	18.12%	18.84%	14.24%	16.02%	100.00%
SALARIES-ADMIN	$1,919	$1,549	$1,916	$1,993	$1,507	$1,695	$10,578
SALARIES-CLERIC	1,012	817	1,011	1,052	795	894	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	9	7	8	50
WORK COMP INS	24	19	24	25	19	21	132
SUPPLIES	37	30	37	38	29	33	204
TELEPHONE	94	76	94	98	74	83	518
EMPL BENEFITS	506	409	506	526	398	447	2,791
PAYROLL TAXES	273	220	273	284	214	241	1,505
TRAVEL	215	173	214	223	169	190	1,183
IN SERVICE	4	3	4	4	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	307	248	307	319	241	271	1,694
INS-PROP,LIAB,WC	29	23	29	30	23	25	158
DEPRECIATION	139	112	139	144	109	123	765
RENT	308	248	307	320	242	272	1,696
MAINTENANCE	47	38	46	48	37	41	257
FEES & PUBLIC	5	4	5	5	4	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$4,927	$3,976	$4,920	$5,117	$3,869	$4,351	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,328	6,721	8,317	8,651	6,540	7,355	45,912
EQUIP - CURR	3,834	3,094	3,829	3,983	3,011	3,386	21,138
EQUIP - FULLY DEP	1,018	822	1,017	1,058	800	899	5,614
BLDG - PRIOR	1,220	985	1,218	1,267	958	1,077	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.02%	13.93%	18.20%	18.16%	14.04%	16.65%	100.00%
SALARIES-ADMIN	$2,012	$1,473	$1,925	$1,921	$1,486	$1,761	$10,578
SALARIES-CLERIC	1,062	777	1,016	1,013	784	929	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	10	7	9	9	7	8	50
WORK COMP INS	25	18	24	24	19	22	132
SUPPLIES	39	28	37	37	29	34	204
TELEPHONE	98	72	94	94	73	86	518
EMPL BENEFITS	531	389	508	507	392	465	2,791
PAYROLL TAXES	286	210	274	273	211	251	1,505
TRAVEL	225	165	215	215	166	197	1,183
IN SERVICE	4	3	4	4	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	322	236	308	308	238	282	1,694
INS-PROP,LIAB,WC	30	22	29	29	22	26	158
DEPRECIATION	146	107	139	139	107	127	765
RENT	323	236	309	308	238	282	1,696
MAINTENANCE	49	36	47	47	36	43	257
FEES & PUBLIC	5	4	5	5	4	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,167	$3,783	$4,943	$4,932	$3,814	$4,521	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,734	6,394	8,356	8,337	6,448	7,642	45,912
EQUIP - CURR	4,021	2,944	3,847	3,838	2,968	3,519	21,138
EQUIP - FULLY DEP	1,068	782	1,022	1,019	788	934	5,614
BLDG - PRIOR	1,279	937	1,224	1,221	944	1,119	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.64%	13.64%	18.11%	18.77%	13.52%	17.31%	100.00%
SALARIES-ADMIN	$1,972	$1,443	$1,916	$1,986	$1,431	$1,831	$10,578
SALARIES-CLERIC	1,041	761	1,011	1,048	755	966	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	9	7	9	50
WORK COMP INS	25	18	24	25	18	23	132
SUPPLIES	38	28	37	38	28	35	204
TELEPHONE	97	71	94	97	70	90	518
EMPL BENEFITS	520	381	505	524	377	483	2,791
PAYROLL TAXES	281	205	273	283	204	261	1,505
TRAVEL	221	161	214	222	160	205	1,183
IN SERVICE	4	3	4	4	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	316	231	307	318	229	293	1,694
INS-PROP,LIAB,WC	29	22	29	30	21	27	158
DEPRECIATION	143	104	139	144	104	133	765
RENT	316	231	307	318	229	294	1,696
MAINTENANCE	48	35	46	48	35	44	257
FEES & PUBLIC	5	3	5	5	3	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,064	$3,704	$4,918	$5,099	$3,673	$4,702	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,560	6,261	8,314	8,620	6,209	7,948	45,912
EQUIP - CURR	3,941	2,883	3,828	3,969	2,859	3,659	21,138
EQUIP - FULLY DEP	1,047	766	1,017	1,054	759	972	5,614
BLDG - PRIOR	1,254	917	1,218	1,263	909	1,164	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.81%	14.02%	17.64%	18.37%	14.04%	17.12%	100.00%
SALARIES-ADMIN	$2,679	$1,997	$2,512	$2,617	$2,001	$2,439	$14,245
SALARIES-CLERIC	1,413	1,054	1,325	1,381	1,055	1,287	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	213	159	199	208	159	194	$1,131
ACCOUNTING	9	6	8	8	6	8	$45
WORK COMP INS	27	20	26	27	20	25	$145
SUPPLIES	106	79	99	104	79	97	$564
TELEPHONE	64	48	60	63	48	59	$343
EMPL BENEFITS	518	386	486	506	387	472	$2,756
PAYROLL TAXES	350	261	328	342	261	319	$1,861
TRAVEL	84	62	79	82	63	76	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	13	16	17	13	16	$91
OWNERS COMP	310	231	291	303	232	283	$1,650
INS-PROP,LIAB,WC	33	24	31	32	24	30	$174
DEPRECIATION	144	107	135	140	107	131	$763
RENT	327	244	307	319	244	298	$1,739
MAINTENANCE	53	39	49	51	39	48	$280
FEES & PUBLIC	5	4	4	5	4	4	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,356	$4,738	$5,960	$6,208	$4,746	$5,787	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,953	8,910	11,208	11,675	8,925	10,883	63,553
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	1,714	1,277	1,607	1,674	1,280	1,560	9,111
BLDG - PRIOR	1,265	943	1,186	1,235	944	1,152	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.96%	14.17%	18.66%	17.39%	13.89%	16.93%	100.00%
SALARIES-ADMIN	$2,701	$2,019	$2,658	$2,477	$1,978	$2,412	$14,245
SALARIES-CLERIC	1,425	1,065	1,402	1,307	1,044	1,272	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	214	160	211	197	157	191	$1,131
ACCOUNTING	9	6	8	8	6	8	$45
WORK COMP INS	27	21	27	25	20	25	$145
SUPPLIES	107	80	105	98	78	95	$564
TELEPHONE	65	49	64	60	48	58	$343
EMPL BENEFITS	522	391	514	479	383	466	$2,756
PAYROLL TAXES	353	264	347	324	258	315	$1,861
TRAVEL	84	63	83	77	62	75	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	13	17	16	13	15	$91
OWNERS COMP	313	234	308	287	229	279	$1,650
INS-PROP,LIAB,WC	33	25	32	30	24	29	$174
DEPRECIATION	145	108	142	133	106	129	$763
RENT	330	247	325	302	241	294	$1,739
MAINTENANCE	53	40	52	49	39	47	$280
FEES & PUBLIC	5	4	5	4	3	4	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,407	$4,790	$6,307	$5,876	$4,693	$5,721	$33,794
FIXED ASSETS							
EQUIP - PRIOR	12,050	9,009	11,860	11,051	8,825	10,759	63,553
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	1,727	1,291	1,700	1,584	1,265	1,542	9,111
BLDG - PRIOR	1,275	953	1,255	1,169	934	1,138	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.26%	13.28%	18.84%	17.34%	13.31%	18.97%	100.00%
SALARIES-ADMIN	$2,601	$1,892	$2,683	$2,471	$1,896	$2,703	$14,245
SALARIES-CLERIC	1,372	998	1,416	1,303	1,000	1,426	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	206	150	213	196	151	215	$1,131
ACCOUNTING	8	6	9	8	6	9	$45
WORK COMP INS	26	19	27	25	19	27	$145
SUPPLIES	103	75	106	98	75	107	$564
TELEPHONE	63	46	65	59	46	65	$343
EMPL BENEFITS	503	366	519	478	367	523	$2,756
PAYROLL TAXES	340	247	351	323	248	353	$1,861
TRAVEL	81	59	84	77	59	84	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	12	17	16	12	17	$91
OWNERS COMP	301	219	311	286	220	313	$1,650
INS-PROP,LIAB,WC	32	23	33	30	23	33	$174
DEPRECIATION	139	101	144	132	102	145	$763
RENT	318	231	328	302	231	330	$1,739
MAINTENANCE	51	37	53	49	37	53	$280
FEES & PUBLIC	5	3	5	4	3	5	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,170	$4,487	$6,365	$5,861	$4,498	$6,411	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,604	8,439	11,971	11,023	8,459	12,057	63,553
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	1,664	1,210	1,716	1,580	1,213	1,729	9,111
BLDG - PRIOR	1,228	893	1,267	1,166	895	1,276	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.18%	13.05%	19.11%	16.72%	12.93%	20.01%	100.00%
SALARIES-ADMIN	$2,590	$1,859	$2,723	$2,381	$1,842	$2,850	$14,245
SALARIES-CLERIC	1,366	981	1,436	1,256	972	1,504	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	206	148	216	189	146	226	$1,131
ACCOUNTING	8	6	9	8	6	9	$45
WORK COMP INS	26	19	28	24	19	29	$145
SUPPLIES	103	74	108	94	73	113	$564
TELEPHONE	62	45	66	57	44	69	$343
EMPL BENEFITS	501	360	527	461	356	551	$2,756
PAYROLL TAXES	338	243	356	311	241	372	$1,861
TRAVEL	81	58	85	74	58	89	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	12	17	15	12	18	$91
OWNERS COMP	300	215	315	276	213	330	$1,650
INS-PROP,LIAB,WC	32	23	33	29	23	35	$174
DEPRECIATION	139	100	146	128	99	153	$763
RENT	316	227	332	291	225	348	$1,739
MAINTENANCE	51	37	53	47	36	56	$280
FEES & PUBLIC	5	3	5	4	3	5	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,144	$4,411	$6,460	$5,649	$4,369	$6,762	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,554	8,295	12,148	10,624	8,216	12,716	63,553
EQUIP - CURR	286	205	301	263	203	315	1,574
EQUIP - FULLY DEP	1,656	1,189	1,742	1,523	1,178	1,823	9,111
BLDG - PRIOR	1,223	878	1,285	1,124	869	1,346	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	17.71%	13.84%	19.27%	16.65%	12.57%	19.96%	100.00%
SALARIES-ADMIN	$2,523	$1,972	$2,745	$2,372	$1,790	$2,844	$14,245
SALARIES-CLERIC	1,331	1,040	1,448	1,251	944	1,500	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	200	156	218	188	142	226	$1,131
ACCOUNTING	8	6	9	8	6	9	$45
WORK COMP INS	26	20	28	24	18	29	$145
SUPPLIES	100	78	109	94	71	113	$564
TELEPHONE	61	47	66	57	43	68	$343
EMPL BENEFITS	488	381	531	459	346	550	$2,756
PAYROLL TAXES	330	258	359	310	234	372	$1,861
TRAVEL	79	62	86	74	56	89	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	16	13	18	15	11	18	$91
OWNERS COMP	292	228	318	275	207	329	$1,650
INS-PROP,LIAB,WC	31	24	34	29	22	35	$174
DEPRECIATION	135	106	147	127	96	152	$763
RENT	308	241	335	290	219	347	$1,739
MAINTENANCE	50	39	54	47	35	56	$280
FEES & PUBLIC	4	3	5	4	3	5	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$5,985	$4,677	$6,511	$5,628	$4,247	$6,746	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,256	8,796	12,244	10,584	7,986	12,687	63,553
EQUIP - CURR	279	218	303	262	198	314	1,574
EQUIP - FULLY DEP	1,614	1,261	1,755	1,517	1,145	1,819	9,111
BLDG - PRIOR	1,191	931	1,296	1,120	845	1,343	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	17.54%	13.23%	19.40%	16.34%	13.70%	19.80%	100.00%
SALARIES-ADMIN	$2,498	$1,884	$2,763	$2,328	$1,952	$2,820	$14,245
SALARIES-CLERIC	1,318	994	1,458	1,228	1,030	1,488	7,515
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	198	150	219	185	155	224	1,131
ACCOUNTING	8	6	9	7	6	9	45
WORK COMP INS	25	19	28	24	20	29	145
SUPPLIES	99	75	109	92	77	112	564
TELEPHONE	60	45	66	56	47	68	343
EMPL BENEFITS	483	365	534	450	378	546	2,756
PAYROLL TAXES	326	246	361	304	255	369	1,861
TRAVEL	78	59	86	73	61	88	445
IN SERVICE	4	3	4	3	3	4	21
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	16	12	18	15	13	18	91
OWNERS COMP	289	218	320	270	226	327	1,650
INS-PROP,LIAB,WC	31	23	34	28	24	34	174
DEPRECIATION	134	101	148	125	105	151	763
RENT	305	230	337	284	238	344	1,739
MAINTENANCE	49	37	54	46	38	55	280
FEES & PUBLIC	4	3	5	4	3	5	25
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,926	$4,470	$6,554	$5,522	$4,631	$6,690	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,145	8,407	12,326	10,385	8,709	12,582	63,553
EQUIP - CURR	276	208	305	257	216	312	1,574
EQUIP - FULLY DEP	1,598	1,205	1,767	1,489	1,248	1,804	9,111
BLDG - PRIOR	1,179	890	1,304	1,099	922	1,331	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

ALLOCATION PERCENTAGES USED ON
MONTHLY ALLOCATIONS - PAGE27

OCCUPIED

DAYS 2000	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2453	1828	2186	1874	663	1482	2008	12494
FEBRUAR	2205	1686	2168	1746	597	1442	1996	11840
MARCH	2383	1773	2434	1904	604	1569	2285	12952
APRIL	2273	1671	2387	1783	641	1496	2155	12406
MAY	2301	1691	2252	1910	600	1448	2073	12275
JUNE	2211	1730	2175	1793	603	1426	1906	11844
JULY	2317	1823	2396	1846	652	1459	1889	12382
AUGUST	2249	1817	2342	1861	673	1516	1966	12424
SEPTEM	2163	1790	2174	1709	665	1606	1899	12006
OCTOBER	2249	1815	2246	1709	627	1766	1986	12398
NOVEMBE	2288	1675	2189	1590	594	1689	2002	12027
DECEMBE	2294	1678	2228	1642	668	1664	2130	12304
TOTAL	27386	20977	27177	21367	7587	18563	24295	147352
								147352

OCCUPIED

DAYS 2001	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,278	1,698	2,136	1,630	595	1,701	2,074	12,112
FEBRUAR	2,100	1,570	2,067	1,408	518	1,538	1,875	11,076
MARCH	2,277	1,656	2,349	1,605	558	1,660	2,366	12,471
APRIL	2,198	1,578	2,311	1,461	560	1,563	2,419	12,090
MAY	2,210	1,727	2,404	1,535	543	1,568	2,491	12,478
JUNE	2,141	1,615	2,368	1,691	304	1,673	2,417	12,209
JULY	2,114	1,602	2,434	2,119	0	1,702	2,441	12,412
AUGUST								0
SEPTEM								0
OCTOBER								0
NOVEMBER								0
DECEMBER								0
TOTAL	15,318	11,446	16,069	11,449	3,078	11,405	16,083	84,848
								84,848

ALLOCATION

PERCENTAGE 2000	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	19.63%	14.63%	17.50%	20.31%	11.86%	16.07%	100.00%
FEBRUARY	18.62%	14.24%	18.31%	19.79%	12.18%	16.86%	100.00%
MARCH	18.40%	13.69%	18.79%	19.36%	12.11%	17.64%	100.00%
APRIL	18.32%	13.47%	19.24%	19.54%	12.06%	17.37%	100.00%
MAY	18.75%	13.78%	18.35%	20.45%	11.80%	16.89%	100.00%
JUNE	18.67%	14.61%	18.36%	20.23%	12.04%	16.09%	100.00%
JULY	18.71%	14.72%	19.35%	20.17%	11.78%	15.26%	100.00%
AUGUST	18.10%	14.62%	18.85%	20.40%	12.20%	15.82%	100.00%
SEPTEMBER	18.02%	14.91%	18.11%	19.77%	13.38%	15.82%	100.00%
OCTOBER	18.14%	14.64%	18.12%	18.84%	14.24%	16.02%	100.00%
NOVEMBER	19.02%	13.93%	18.20%	18.16%	14.04%	16.65%	100.00%
DECEMBER	18.64%	13.64%	18.11%	18.77%	13.52%	17.31%	100.00%

ALLOCATION

PERCENTAGE 2001	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	18.81%	14.02%	17.64%	18.37%	14.04%	17.12%	100.00%
FEBRUARY	18.96%	14.17%	18.66%	17.39%	13.89%	16.93%	100.00%
MARCH	18.26%	13.28%	18.84%	17.34%	13.31%	18.97%	100.00%
APRIL	18.18%	13.05%	19.11%	16.72%	12.93%	20.01%	100.00%
MAY	17.71%	13.84%	19.27%	16.65%	12.57%	19.96%	100.00%
JUNE	17.54%	13.23%	19.40%	16.34%	13.70%	19.80%	100.00%
JULY	17.03%	12.91%	19.61%	17.07%	13.71%	19.67%	100.00%
AUGUST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
SEPTEMBER	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
OCTOBER	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
NOVEMBER	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
DECEMBER	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!